State Health Improvement Plan for the Elimination of Health Disparities

South Carolina Department of Health
and Environmental Control

FOREWORD

The *State Health Improvement Plan for the Elimination of Health Disparities* (SHIP- EPD) is based on a Health Disparities Study Report, that was developed in 2002 as a result of a proviso included in the FY 2002 State Appropriations Bill..

The SHIP- EPD serves to guide the state's efforts to assist in the coordination of efforts and implementation of strategies toward eliminating health disparities. It includes the initial seven (7) recommendations along with Healthy People 2010 related goals to address priority health disparity areas. The Plan will also be expanded to include additional recommendations, actions steps and measurable outcomes for eliminating health disparities.

SC Department of Health and Environmental Control (SC DHEC) is charged with providing leadership and coordinates with public /private agencies, institutions and organizations at the state and community levels in the implementation of the SHIP-EPD.

9.50(DHEC: Health Disparities Study) *The Department of Health and Environmental Control must prepare a state health improvement plan with specific goals similar to the national Healthy People 2010 goals and targeting health disparities among our State's minority population. The Plan should address the areas of diabetes, cardiovascular disease, stroke, cancer and HIV/AIDS. Recommendations addressing coordination of services, elimination of duplication and coordination of federal and state funding should be included. DHEC must coordinate with public and private health care institutions, state agencies and providers in the development of the plan. The State Health Improvement Plan must be submitted to the Governor and the Chairmen of the Senate Finance, House Ways and Means, Senate Medical Affairs and House Medical, Military, Public and Municipal Affairs Committees not later than June 30, 2002.*

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INTRODUCTION

While there have been improvements in health status for most South Carolinians over the past decade, the overall health status of the state's minority citizens is poor. As a group, minorities in South Carolina, and particularly, African Americans, live sicker and die younger than any other population from a number of health conditions. Significant health disparities or gaps exist between the white population and minority groups in the state.

The National Institutes of Health defines health disparities as the differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States[1].

Elimination of Health Disparities is a national priority and is one of two overarching goals for Healthy People 2010, the nation's health promotion and disease prevention agenda for this decade. Building on initiatives pursued in the past two decades, Healthy People 2010 outlines a comprehensive set of health objectives that serve as the basis for the development of state and community plans to improve the health status of the nation[2]. Department of Health and Human Services, Secretary Tommy Thompson has challenged the nation to "eliminate disparities in health among all population groups by 2010". In response, numerous states have implemented or adopted legislation, policy and/or program initiatives to aggressively address this significant public health issue in their communities.

South Carolina joins other states in working to meet this challenge through planning and implementing initiatives to eliminate racial and ethnic health disparities, thus, improving the health for all of its citizens. During FY 2001, the *Closing the Gap Program* ($1 million) was included in the Governor's Executive Budget and legislation was introduced (but not passed) to support community-based health disparity initiatives. South Carolina Department of Health and Environmental Control (SC DHEC) has established the elimination of health disparities as an agency priority. A *Commissioner's Task Force on Eliminating Health Disparities* was created to provide recommendations on addressing health disparities. One of the eight goals in the agency's strategic health plan is: *Improving Health for All and Eliminating Health Disparities*.

Eliminating health disparities holds particular significance for the state, which has a large (34%) racial and ethnic minority population. Additionally South Carolina is predominately rural (where a large number of minorities reside) and face many challenges which impact health status, i.e., high poverty levels, lack of health services and resources, lack of insurance, etc.

As we strive to improve the quality of life for all South Carolinians, it is critical that racial and ethnic health disparities be eliminated. If these disparities or gaps in health persist, the state as a whole will be less likely to achieve optimal health. The opportunity currently exists to enhance health disparity efforts in the state by examining how initiatives can be better coordinated and taking the necessary action to effectively address this important issue.

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[1] The NIH Workgroup on Health Disparities, September 1999

[2] US Department of Health and Human Services. Healthy People 2010 (Conference Edition, in Two Volumes). Washington, DC: January 2000.

BACKGROUND AND SUMMARY OF REPORT DEVELOPMENT

During the 2001 session of the General Assembly, proviso 9.50 was included in the FY 2002 State Appropriations Bill. The proviso directed the SC DHEC to develop a plan to address coordination of services, the elimination of duplication and coordination of federal, state and other resources toward improving the health status of racial and ethnic minorities in the state.

In an effort to accomplish the tasks set forth in the proviso, DHEC convened a Workgroup involving key players that had an expressed interest in eliminating health disparities and had a direct or indirect responsibility for ensuring the health of South Carolina's citizens. The Health Disparities Study Workgroup was chaired by the SC DHEC Deputy Commissioner for Health Services and staffed by the Office of Minority Health. The broad-based workgroup was comprised of representatives from state agencies and other public and private agencies and organizations (Appendix A).

The Workgroup met three times over the course of a six-month period and provided input electronically or through the mail.

The group was charged with the following tasks:

1. Identify information on public and private health initiatives focused on eliminating racial and ethnic health disparities/ targeting minorities across the state

2. Identify ways to promote joint efforts among public and private organizations toward eliminating racial and ethnic health disparities

3. Provide recommendations for the plan and process for development of a State Health Improvement Plan with an emphasis on the elimination of health disparities.

In development of this study the Workgroup reviewed key information including health disparity and other baseline data to assess South Carolina's health status and progress towards meeting Healthy People 2010 objectives. The group identified health disparity efforts in the state and key issues and barriers to coordination of efforts. Issues of concern centered around lack of progress toward Healthy People 2010 Goals; varying definitions and limited knowledge of health disparity initiatives and their impact; location of initiatives; communication; and funding concerns, particularly for community based initiatives. Further explanation of these issues can be found on *pages 8 and 9*. Information was also collected concerning other state initiatives. Issues that evolved from a discussion of key decision-makers and leaders in health concerning approaches to addressing health disparities were also reviewed.

This provided the basis for the following seven recommendations, which were developed to assist in the coordination of efforts and implementation of strategies toward eliminating health disparities. A more in-depth description of the recommendations begins on *page 11*.

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SUMMARY OF RECOMMENDATIONS

1. *Create a Single, Shared Definition for "Health Disparity" and "Health Disparity Initiative"*
   There is a need to have a common definition for "health disparity" and "health disparity initiative" to distinguish these from general health initiatives. The definitions should be used to improve public awareness about the problem; engage and mobilize the public; and to create a shared vision of health for South Carolina.

2. *Establish a Health Disparities Board*
   A Health Disparities Board supported by the legislature including a broad spectrum of stakeholders should be created. The Board would work collaboratively with the SC Department of Health and Environmental Control-Office of Minority Health in exploring and creating effective health disparity efforts polices, and opportunities for research.

3. *Develop a Statewide Database of Health Disparity Programs and Initiatives*
   A statewide database is needed to provide information about health disparity initiatives (including outcomes/results) to facilitate better coordination and collaboration of health disparity efforts in the state.

4. *Establish a System of Accountability for Outcomes*
   Evaluation models should be developed that can assess both short and long term individual and systemic changes as a result of an initiative. All initiatives and programs should demonstrate outcomes for continued funding. Training, technical assistance, and funding should also be made available to community based organizations (CBOs) to develop their evaluation skills and to support and assure evaluation of efforts and outcomes.

5. *Invest more Funding in Prevention and Education*
   More funding should be invested in prevention and education that will influence behavior and lifestyle changes. Prevention initiatives, or interventions, need to be culturally appropriate, target individuals early in life, and address institutional systems.

6. *Establish Opportunities for Collaboration and Partnership Development*

   Linkages should be created to broader social and economic issues. An annual Summit should be established to provide a forum for sharing information, ideas, building partnerships and developing a shared agenda to address health disparities. Local symposia and other events should also be held for ongoing dialogue at the community level. The business sector needs to be engaged in health disparity initiatives as a collaborative partner. In addition to business, participants in these events should include community members and individuals that represent healthcare, education, economic development, and policy and other decision-makers.

7. *Implement Models of Community Development*
   There is a need to identify and train community leaders to enhance capacity and participation in planning and implementing community-based health initiatives. Healthcare professionals and paraprofessionals play a key role in disseminating prevention messages and providing care, particularly to rural and poor communities.

Healthy People 2010 Related Goals

The following should be considered as strategic goals for the state in reaching Healthy People 2010 targets to address priority disparity areas:

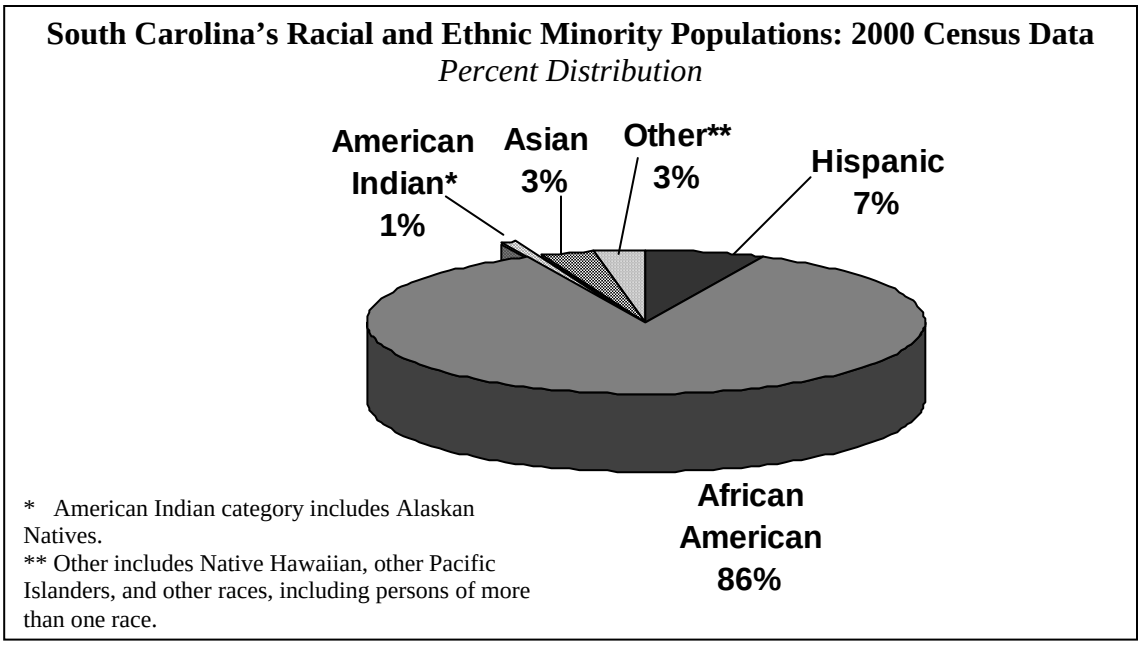
- Reduce the number of newly diagnosed HIV cases among African Americans and other minority groups
- Reduce deaths due to stroke and heart disease among minorities
- Reduce the rate of complications and deaths due to diabetes
- Reduce death and disability due to cancers that contribute to disproportionate rates of morbidity and mortality among minorities (i.e., prostate, breast)
- Increase the percentage of infants who survive the first year of life
- Establish and maintain partnerships and linkages to promote and provide culturally appropriate and targeted services, programs and health promotion/prevention initiatives for African Americans and other minorities

OVERVIEW

SOUTH CAROLINA'S RACIAL MINORITIES

Racial and ethnic minorities account for nearly 34% of South Carolina's population[3]. South Carolina's racial and ethnic minority population is largely African Americans, with a growing Hispanic population. African Americans represent nearly 90 percent of all racial and ethnic minorities in the state. There has been a substantial amount of growth in South Carolina's minority populations in the past decade: the Hispanic population has more than doubled; Asian-Pacific Islanders have increased by 65 percent; American Indians have increased by 66% and African Americans have increased by 14 percent.

Figure 1. Distribution of South Carolina's Racial and Ethnic Minority Population



SOUTH CAROLINA HEALTH STATUS AND HEALTHY PEOPLE 2010

South Carolina's overall death rates for infants, stroke, heart disease, and cancer continue to exceed the nation's target rates defined by Healthy People 2010. In addition, the state's annual case rate for AIDS is much higher than the target rate for the nation and has increased with time. Death rates for diabetes are the only target area for which the state's average is below that of the nation's goal. Despite this fact, there have been noted increases in overall diabetes death rates for the state largely due to unequal sharing of disease burden and deaths. While diabetes deaths among whites have begun to decline, increased deaths among racial and ethnic minority populations have lead to increases in the overall death rate for the state. Without enhanced interventions, the diabetes death rates for the state could well exceed the Healthy People 2010 target rate.

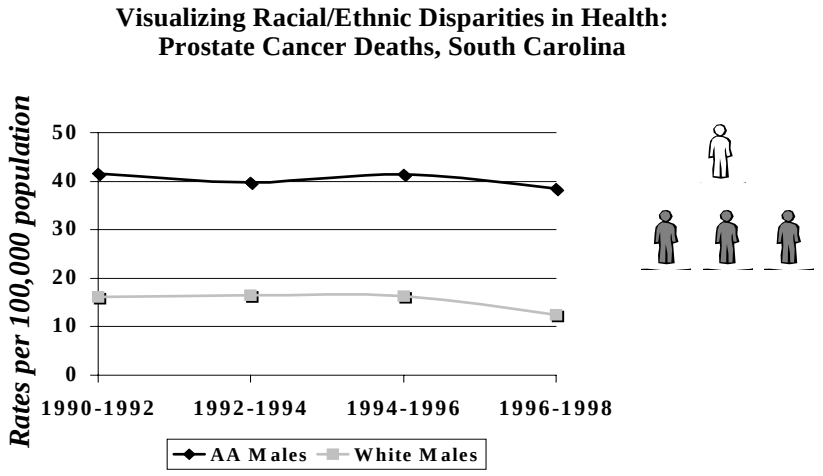
[3] US Bureau of the Census, 2000 data. Racial and ethnic minority population groups include persons of Hispanic origin as well as African Americans, American Indians and Alaskan Natives, Native Hawaiian or Other Pacific Islander or combinations of one or more racial categories.

South Carolina is making some progress in improving health status with regards to infant death, stroke, heart disease and certain cancers. Overall death rates in the state for the above health conditions have either slowed or begun to decline. However, these improvements were not equally noted among all population groups. While infant death rates among whites and minorities began to decline in year 2000, the gap in health status between the groups continues to grow. A similar trend is also evident in declines for stroke, heart disease, breast cancer and prostate cancer death rates. Varying rates of decline for deaths have resulted in persistent gaps in health status between population groups

THE BURDEN OF HEALTH DISPARITIES

Health disparities occur when there are unequal burdens of disease among population groups. An example can be seen in South Carolina's prostate cancer death rates for African American men and White men. African American men are three times more likely to die of the disease than are White men. Figure 2 depicts the gap in health status.

Figure 2. South Carolina Prostate Cancer Death Rates: 1990 - 1998



Data Source: SCDHEC Division of Biostatistics

Racial and ethnic minorities continue to carry an unequal share of disease burden and deaths for various health conditions in South Carolina. For example:

- Infant death rates are ***2.6 times higher*** for racial and ethnic minorities than whites in the state.
- Death rates among minorities for both cancer and heart disease are ***nearly 1.5 times*** that of whites.
- Racial and ethnic minorities are more than ***3 times more*** likely to die of diabetes and are ***2 times more*** likely to die of stroke than are whites.
- Racial and ethnic minorities in the state are ***over 5 times more*** likely to be reported with HIV than are whites.

Appendix B1 and B2 provides additional data and information concerning the priority health disparity areas.

STATE HEALTH INITIATIVES

South Carolina

An initial task for the Workgroup was to identify health disparity efforts in which they were involved or had knowledge of across the state. This information was added to the existing initiatives compiled by the SC DHEC Office of Minority Health. Appendix C provides a listing of select health disparity initiatives. Several initiatives/efforts were identified by the Workgroup. Only a limited number identified, however, were specifically targeting minority populations. Information was also collected on resources allocated for each effort; funding source; lead and partnership agency involvement; and area of focus (i.e., policy, research, service, health promotion, outreach or minority health professions development) when available. It became apparent during this process that there are limitations regarding knowledge about activities/initiatives and services that exist across the state that specifically focus on minority health concerns versus those that address health in general. The maps located in Appendix D1 and D2 depict the distribution of activities/services identified by the group. They reviewed the geographic distribution of activities/services across the state regarding cardiovascular disease, HIV/AIDS, stroke, diabetes, cancer, and infant mortality. Data reveal that health disparities exist across South Carolina, however, initiatives tend to be driven by the successful ability to secure resources. Therefore, some areas of the state do not have resources to support health disparity efforts. The majority of the initiatives focused on HIV/AIDS, were service related, and federally funded.

Other State Initiatives/Efforts

In addition to identifying South Carolina's efforts, the group believed it would be beneficial to examine what other states are doing to address the elimination of racial and ethnic health disparities. The Office of Minority Health conducted a survey of other states.

The following summarizes select initiatives that reflect similar strategies considered by the Workgroup. These include legislation or other policy initiatives and resources to support coordinated/collaborative efforts; and health disparity initiatives, particularly at the community level. Additional information on these and other state initiatives can be found in Appendix E.

Florida-addressed racial and ethnic disparities through an appropriations bill which allocated $5 million to the Department of Health to implement and administer the *Closing the Gap* grant program. This initiative provided grants to local counties and organizations with the intent to increase community-based health promotion and disease prevention activities.

Ohio-General Assembly passed Amended Substitute House Bill 171 in July of 1987, creating the Ohio Commission on Minority Health. The Commission was the first concerted effort by a state to address the disparity in health status between majority and minority populations. The Commission is an autonomous state agency with a biennial appropriation of $3.5 million dollars of general revenue funds.

Tennessee-General Assembly passed legislation to allow a $3 million allotment of Tennessee's Tobacco Settlement for the Office of Minority Health to reduce tobacco use in African Americans. $1.5 million was intended for operation of the 6 Regional Minority Health Coalitions ($250,000 annually per Region).

Tennessee- established **Regional Minority Health Coalitions**, (RMHC)) which provide a collaborative community forum for business leaders, health and other professionals, and interested citizens to discuss health concerns that are specific to the local arena. These coalitions assist in coordinating issues that impact health in both rural and urban communities with general emphasis on economic and community development, education and health. Based in the regional areas of the state, the Coalitions have coordinators active in public and private sector health organizations. The coalitions receive technical assistance and support from the Tennessee Office of Minority Health through consultation, information resources, database sharing and networks.

Indiana-addressed minority health initiatives through the **Indiana Minority Health Coalition, Inc,** which is driven by a non-government grassroots organization. This group developed the legislation, cultivated bipartisan support and continues to work to increase funding each year.

Pennsylvania- funded a minority health partnership to conduct planning and implementation of innovative programs, aimed at eliminating health disparities. As a 3-year pilot, each grantee will receive a total of $250,000 to address health disparities in the 6-targeted areas affecting racial and ethnic minorities identified by HHS.

The Association of State and Territorial Health Officials (ASTHO) and the National Association of County and City Health Officials has compiled a listing of efforts nationwide that address eliminating health disparities in ***Health Departments Take Action: A Compendium of State and Local Models Addressing Racial and Ethnic Disparities in Health, 2001***. A closer examination of this publication and information gathered in the survey can assist in the development of policies, strategies and initiatives to address improving the health status of the state's minority population.

KEY ISSUES/ BARRIERS

It was the consensus of the Workgroup that the long-term outcome of the plan should focus on creating sustained behavioral and systems changes to promote health and eliminate health disparities. As such, the group identified key issues, barriers to coordination of services and opportunities to eliminate duplication as appropriate to affect change. The following issues were of concern:

- **Limited or lack of progress toward HP 2010 goals**
  While some progress has been made for overall death rates for infants, heart disease, stroke, cancer, diabetes, HIV/AIDS, without enhanced interventions, South Carolina could well exceed the Healthy People 2010 target rates.

- **Need for a universal working definition of health disparity initiative/efforts**
  The lack of a universal shared definition of a health disparity initiative adversely impacts the ability to identify, coordinate and /or evaluate efforts.

- **Limited knowledge about various health disparity efforts in South Carolina and other states**
  There are limitations regarding knowledge about activities/initiatives and services that exist across the state that specifically focus on minority health concerns versus those that address health in general. There is also a need to have more information about how other states are addressing this issue.

- **Lack of a central database or collection point/clearing house for information related to health disparity initiatives**
  There is a need to enhance existing efforts of SC DHEC- Office of Minority Health in identifying and compiling health disparity initiatives with a central database to facilitate input and access to information about health disparity initiatives in the state.

- **Geographic distribution of initiatives not consistent with the areas of greatest disparities across the state**
  Health disparities exist across South Carolina, however, the location of many of these efforts reflect areas where individuals and /or organizations have been successful in securing grant funds or other resources. This leaves some geographic areas with high disparity rates, a lack or limited resources to support initiatives.

- **Limited knowledge of the impact of efforts on reducing or eliminating health disparities**
  There has been limited evaluation and research on successful models that impact racial and ethnic health disparities. There is a need to provide more support for research and evaluation models to identify and adapt best or promising practices.

- **Lack of communication between key players in the state**
  There is a lack of communication and limited opportunities for collaboration and dialogue among those who plan, and implement initiatives; individuals in public policy and decision-making roles; the community; and others areas such as healthcare, business, education, etc. who can address issues impacting health disparities.

- **Funding stream(s) restraints**
  Many of federally funded initiatives are categorical grants targeting specific health disparity areas which require that activities and resources be directed only toward the specified health conditions, e.g. cardiovascular disease, HIV/AIDS, stroke, diabetes, infant mortality, and cancer.

- **Limited funding for community-based initiatives**
  While models of promising practices point to community based, community- driven, culturally competent approaches as key elements to successful health disparity efforts, resources have not traditionally been targeted to community based health initiatives. When funding is available, many community-based organizations may need training, technical assistance and consultation to enhance their capacity in managing, implementing and evaluating initiatives.

- **Limited amount of state resources identified as going toward health disparities**
  Most health disparity initiatives in the state are federally funded. Because funding sources directs the focus of initiatives, limited state resources reduces the flexibility to plan and implement initiatives based on specific community needs.

OTHER INPUT

In addition to the Workgroup, the Director of Health and Human Service Policy in the Governor's Office convened a meeting of stakeholders including key decision-makers and health leaders (Appendix F). The purpose was to solicit their input and perspectives concerning a coordinated approach to address health disparities in the state. Their discussion centered around the following issues.

- Budget constraints, particularly those involving the provision of Medicaid services to qualified persons in need of assistance. They believed that issues regarding Medicaid eligibility and reimbursement were critical and must be addressed and resolved before any meaningful efforts to address health disparities could be successfully broached.

- Utilize a broad-based approach that includes involvement from: the education, faith, housing, business, and agriculture communities, with specific agendas being prepared for the business sector.

- Promising practices should be catalogued.

- Solicit private resources, in addition to state and federal resources, to build strong public/private partnerships.

- Plan a Summit as an opportunity to exchange information on successes and challenges toward eliminating racial and ethnic health disparities and coordinating services across the state.

- The responsibility of coordinating grants and services should be elevated as a priority for the appropriate entity (for example, the SC DHEC Office of Minority Health).

Subsequent meetings have been planned to continue discussion in these areas.

RECOMMENDATIONS

The recommendations that follow represent the key strategies developed by the Workgroup to address identified issues and to assist in the coordination of health disparity efforts.

1. **Create a Single, Shared Definition for "Health Disparity" and "Health Disparity Initiative"**

    - Use the National Institutes of Health (NIH) definition as a guideline including dental and mental health; and develop criteria to define a health disparity initiative that distinguishes it from efforts that address health in general.

    - Use these definitions to improve public awareness about the problem in our state; to engage and mobilize the public; to inform the legislature, other policy/decision makers and stakeholders about the nature, causes and implications of health disparities; and to create a shared, common vision of health for the state of South Carolina.

    - The common definitions and common vision should be used to begin developing specific agendas in both the legislative and business communities so that these stakeholders are investing in building the capacity of communities to address health disparities.

2. **Establish a Health Disparities Board**

    - The Board must have legislative backing and authority to affect policy and complement the work of SC Department of Health and Environmental Control-Office of Minority Health and other health disparity efforts in the state.

    - It should include a broad range of stakeholder groups and involve community participation.

    - The responsibilities of the Board should include, but not be limited to:
        - making recommendations about programs and policies
        - finding funding for collaborative efforts
        - examining policies and other structures that limit the collaboration of programs, services or other initiatives
        - investigating and promoting best and promising practices;
        - establishing a community-grants program where communities can apply for funding to develop and implement health disparity initiatives.
        - creating an Institute focused on information, research, and scholarly thought similar to the Michigan Public Health Institute (Appendix G)

    - Possible placements for the Institute:
        - Historically Black Colleges and Universities, School of Public Health, or Faith-Based organizations - There is a built-in interest and momentum in these organizations and this is also a way to address building capacity for research, training professionals, and building critical infrastructure.

- Training Institution- this would address training minority health professionals, as well as creating culturally competent doctors of all races.

- Create a separate organization (501C3) that is comprised of partnerships among many organizations with SC Department of Health and Environmental Control- Office of Minority Health serving as a focal point for the coordination of these efforts.

- There are many current models of how the Board could work. Successful models should be reviewed and legislative guidance sought to identify the structure that would be most applicable and effective for our state.

3. Develop a Statewide Database of Health Disparity Programs and Initiatives

- A statewide database of programs and initiatives addressing health disparities should be developed.

- Local databases should be established and linked to the statewide database.

- A state coordinator would oversee this database and provide information and technical assistance to those wanting to initiate health disparities efforts. The focus of the database would be on increasing collaboration and coordination.

- The statewide coordinator and database could be housed at the Institute created by the Health Disparity Board. Because of the resources needed to fund such an endeavor, the database could be housed initially at DHEC in the Office of Minority Health while a virtual structure based on systems already in place is being explored.

- It is imperative to also explore current provisos that deal with integrated database systems and explore other database systems that can be used as a model, such as the proposed "Real Choice" database at the Department of Health and Human Services.

- The database should be available for public access. All parties applying for grants or other funding to implement a health disparity effort will be encouraged to use the database to maximize collaboration.

- It is also essential to educate funders on the information in the database as well as for the database to contain information on outcomes.

- The Board and state coordinator can work with local funders to include using the database and acquiring Memorandum of Agreements (MOA's) that show partnerships are formed as a part of the funding requirements. Evidence of partnerships should be more than just a letter of support, but should be more formalized MOA's.

- To access and collaborate with funders, existing structures such as the Grantmaker's Network, the Secretary of State's Office, and the single point of contact for federal grants in the Office of the Governor should be used.

- The process should be open to Community Based Organizations (CBO's) and other individuals who want to start community-based, innovative efforts.

4. Establish a System of Accountability for Outcomes

- This requires the development of evaluation models that can assess both short and long term individual and systemic changes occurring as a result of an initiative. There are models of evaluation such as the CENTERD project that could be applied.

- CBO's should receive technical assistance and training up front in order to build capacity to conduct evaluation and all grants should fund evaluation of the initiative.

- State agencies that pass through dollars should also provide funding and training for evaluation of outcomes.

- There are many efforts in place that are trying to build the infrastructure and capacity of CBO's to conduct evaluation such as the United Way and the 1890 Institute. This effort should partner and capitalize on those existing initiatives.

5. Invest more Funding in Prevention and Education

- More resources should be invested in prevention and education to produce lifestyle and behavior changes.

- Many of these interventions should be aimed at policy and environmental changes which impact institutional and educational systems in which people live, work and play.

- These interventions should start early and be multifaceted to address individual, systemic and cultural factors.

- These should also be long term efforts that can be sustained and produce outcomes.

- The emphasis should be on decreasing incidence (number/rate of new cases) instead of prevalence as a way to focus on prevention and education efforts.

6. Establish Opportunities for Collaboration and Partnership Development

- Linkages should be created to broader social and economic issues to emphasize that the problem of health disparities is not just a poor or minority issue, but is also one that affects every person in the state**.**

- Hold a Summit and other events that link healthcare providers, and public health, education, economic development and business professionals, legislators, other decision-makers, etc.

- The purpose of the Summit would be to share information, ideas, build partnerships and to develop a shared agenda. The Summit should be conducted annually.

- There is also a need to have regional and local symposia to attract individuals and groups from the community to be a part of the ongoing dialogue.

- There is a need to have a system that appeals to the goals and needs of the business community to increase collaborative efforts with the private sector for funding health disparity initiatives.

7. Implement Models of Community Development

- Identify and train community leaders and develop a base of minority healthcare professionals and paraprofessionals in rural and poor communities to enhance capacity and participation in planning and implementing community based health initiatives.

- Grants in the form of scholarships could be given to individuals for training.

Healthy People 2010 Related Goals

The following should be considered as strategic goals for the state in reaching HP 2010 targets.

- **Reduce the number of newly diagnosed HIV cases among African Americans and other minority groups**
  HP 2010 Target Rate: 1.0 new case per 100,000 persons

- **Reduce deaths due to stroke and heart disease among minorities**
  HP 2010 Target Rate: 48 deaths per 100,000 population (Stroke)
  HP 2010 Target Rate: 166 deaths per 100,000 population (Heart Disease)

- **Reduce the rate of complications and deaths due to diabetes**
  HP 2010 Target Rate: 45 deaths per 100,000 population

- **Reduce death and disability due to cancers that contribute to disproportionate rates of morbidity and mortality among minorities (i.e., prostate, breast)**
  Prostate HP 2010 Target Rate: 28.7 deaths per 100,000 males
  Breast Cancer HP 2010 Target Rate: 22.2 deaths per 100,000 females

- **Increase the percentage of infants who survive the first year of life**
  HP 2010 Target Rate: 4.5 deaths per 1000 live births

- **Establish and maintain partnerships and linkages to promote and provide culturally appropriate and targeted services, programs and health promotion/prevention initiatives for African Americans and other minorities.**

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DEFINITIONS

HEALTH CONDITIONS

AIDS: AIDS stands for acquired immunodeficiency syndrome. An HIV-infected person receives a diagnosis of AIDS after developing one of the AIDS indicator illnesses or on the basis of certain blood tests (CD4+ counts).

Cancer: Cancer develops when cells in a part of the body begin to grow out of control. Although there are many kinds of cancer, they all start because of out-of-control growth of abnormal cells.

Coronary Heart Disease: refers to a range of diseases that reduce the blood supply to the heart muscle.

Diabetes: a chronic disease caused by a body's inability to process or respond to insulin.

HIV: (human immunodeficiency virus), the virus that causes AIDS. This virus is passed from one person to another through blood-to-blood and sexual contact. In addition, infected pregnant women can pass HIV to their baby during pregnancy or delivery, as well as through breast-feeding.

Infant death: death of a live born infant under one year of age.

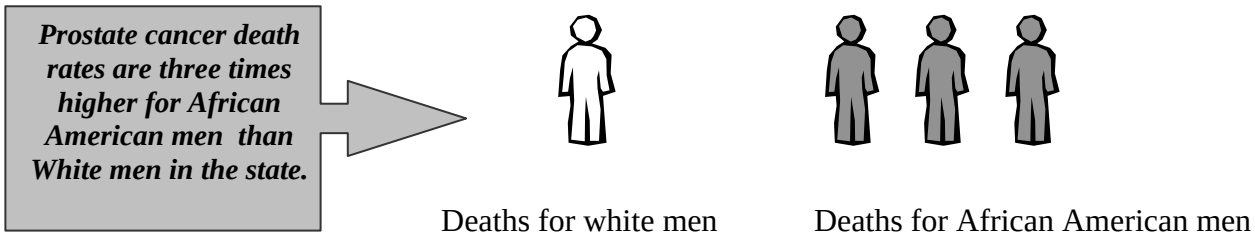
Stroke: A stroke occurs when a blood vessel that brings oxygen and nutrients to the brain bursts or is clogged by a blood clot or some other particle. The rupture or blockage results in oxygen deprivation of the brain, which can lead to nerve cell damage/death.

HEALTH DISPARITIES

Health Disparities: The National Institute of Health defines health disparities as the differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States.

Racial and Ethnic Health Disparities: often referred to as gaps in health status, are differences in health status, disease burden, illness and death experienced between racial and ethnic minority populations and whites.

An example of a health disparity can be seen in prostate cancer death rates in the state. African American men are three times more likely to die of prostate cancer than are white men. The figure below depicts this health disparity.



Healthy People 2010: the nation's health promotion and disease prevention agenda for the first decade of the new century.

RACE AND ETHNICITY

Race: concept used to place human populations into categories for purpose of classification. Race is a sociocultural concept rather than a biological one.

Ethnicity: relates to the sense of identity an individual has based on common ancestry and national, religious, tribal, linguistic, or cultural norms. It generally implies that there are shared values, lifestyles, beliefs, and norms among those claiming affiliation to a specific ethnic group.

Major Racial and Ethnic Categories:

White/Caucasian: refers to people having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Black or African American: refers to people having origins in any of the Black racial groups of Africa. They may also have roots in the United States, Great Britain, the Caribbean, or other countries.

American Indian and Alaska Native: refers to people having origins in any of the original peoples of North and South America (including Central America). They are members who maintain tribal affiliation or community attachment with the more than 500 federally recognized tribes as well as state-recognized or unrecognized tribal organizations.

Asian: refers to people having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent. They may be "Asian Indian," "Chinese," "Filipino," "Korean," Japanese," "Vietnamese," or other Asian ancestry.

Native Hawaiian and Other Pacific Islander: refers to people having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. They may be people who indicate their race or races as "Native Hawaiian," "Guamanian or Chamorro," "Samoan," or other Pacific Islander ancestry.

Some other race: this category was included in Census 2000 for persons who were unable to identify with the five Office of Management and Budget race categories. Respondents who provided write-in entries such as Moroccan, South African, Belizean, or a Hispanic origin (for example, Mexican, Puerto Rican, or Cuban) are included in the Some other race category.

Hispanic or Latino: refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

Racial and Ethnic minority groups*:* for the purposes of this report, racial and ethnic minority population groups refers to persons whose racial/ethnic classification is other than White.

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Statistical Terms

Age adjusted death rates: a weighted average of the death rate on the characteristic of age. This standardized rate represents what the crude rate would be if the measured population had the same age distribution as the standard population (i.e., 2000 US population). Age-adjusting gets rid of fluctuations in the data due to differences in the age distribution of the population.

Crude death rates: the proportion of a population who die of a disease or the relative frequency that death occurs within a specified time period.

Incidence: the number or rate of new cases that develop in a population at risk for the disease over a specified period of time.

Morbidity: measures of various effects of disease on a population.

Prevalence: the number of existing cases of disease or health condition over a specified time period.

Relative Risk Ratio: represents how many times more (or less) likely disease occurs in one population in comparison to another. For example, the year 2000 ratio of Minority stroke death rates (106 deaths per 100,000 population) in comparison to White stroke death rates (73 deaths per 100,000 population) is:

$$\frac{\text{106 deaths per 100,000 population}}{\text{73 deaths per 100,000 population}} = \mathbf{1.5}$$

← Minorities are 1.5 times likely to die of stroke than Whites.

Health Disparities Information/Fact Sheets

Diabetes

Breast Cancer

Prostate Cancer

Heart Disease

Stroke

Infant Death

HIV/AIDS